

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10092

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
 City or town Navre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford
 City or town Navre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Revolution St. extended
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Baby Girl Andrews

3. (b) Social Security Number _____

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Nov. 1, 1947

8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

9. Birthplace

Navre de Grace, Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER

12. Name

Jessie G. Andrews

13. Birthplace

N.C.

MOTHER

14. Maiden name

Mary L. Caudill

15. Birthplace

N.C.

16. Informant

Mr. Jessie G. Andrews

Address

Navre de Grace, Md.

17.

(Burial, cremation, or removal) Which?

Date thereof

Nov. 4, 1947
(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Navre de Grace, Md.

18. Funeral director

R. Madison Mitchell

Address

Navre de Grace, Md.

19.

(Date rec'd by registrar)

Nov. 447G. L. Gennis
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 3, 1947, at 10:30 P.M.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from

Nov. 1, 1947, to Nov. 3, 1947and that I last saw him alive on Nov. 3, 1947

Immediate cause of death

Prematurity

DURATION

Due to

Illness of mother

Due to

flu

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

John Wolbert

M. D. or other _____

Address

Navre de GraceDate signed Nov. 3, 1947

RECEIVED
NOV 5 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10093

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
 City or town Rural Harrod Grace R.D. #1
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Nathaniel Ash

3. (b) Social Security Number

4. Sex

Mr.

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Unknown 1882

8. AGE:

65

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Ind.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Levis Ash

13. Birthplace

Ind.

MOTHER

14. Maiden name

Mary Presterry

15. Birthplace

Ind.

16. Informant

Wm. Walter Ash

Address

Harrod Grace Md. R.D. #1

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 20, 1947
(month) (day) (year)

Cemetery or crematory

Burial
Gravel Hill

Location

Harford Co. Ind.

18. Funeral director

R. Madison Mitchell

Address

Harrod Grace, Md.

19.

(Date rec'd by registrar)

19

47

Bertie B. Knight

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Harford

City or town

Rural Harrod Grace, R.D. #1
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 17

19

47

at

4:15

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

DURATION

Arteriosclerotic Cardio-Vascular DiseaseChronic Hypertrophic Arthritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Lawrence D. D.
Dep. Medical Examiner

Address

Abolition, Ind.Date signed 11/17/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

10094

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harris & GraceCity or town Harris & Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harris Memorial HospitalHow long in hospital or institution? since birth

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State None County NoneCity or town None
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Baby Girl Ayers

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

infant

8. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Nov. 13-47 at 1:30 AM

8. AGE:

Years

Months

Days

If less than one day

7 hrs.20 min.

9. Birthplace

Harris Memorial Hospital
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name

Harrison Ayers

13. Birthplace

Harris Co. Md.

14. Maiden name

Catherine D. Bellum

15. Birthplace

Harris Co. Md.

16. Informant

Mrs Harrison Ayers

Address

Chesapeake Md. R.F.D.

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Nov. 14-1947
(month) (day) (year)

Cemetery or crematory

Calvary

Location

Calvary Harris Co. Md.

18. Funeral director

Henry Tarrance Sons

Address

Chesapeake Md.

19.

Nov. 13
(Date rec'd by registrar)

19

47

G. L. Lewis M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 13 1947 at 8:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 13-47 19... to same 19...and that I last saw her alive on same 19...

Immediate cause of death

Prematurity

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera M.D.

M. D. or other

Address Hospital - Harris & Grace Date signed 11/13/47

RECEIVED
NOV 17 1947
BUREAU P. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1242

10095

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford

City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 816 Adams-St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

. (a) FULL NAME

Benjamin Brooks

3. (b) Social Security Number

4. Sex M 5. Color or race C. 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Minnie Brooks

7. Birth date of deceased (mo., day, yr.) September 16, 1893
 6.(c) If alive, give age _____ years

8. AGE: Years about 54 Months X Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Suburbie, South Carolina
 (Town, county, and state)

10. Usual occupation Railroad

11. Industry or business

12. Name Robert Brooks13. Birthplace No Record14. Maiden name Helen Lott15. Birthplace Suburbie, South Carolina16. Informant Mrs. Minnie BrooksAddress 816 N. Adams St. Harre de Grace, md17. Burial Date thereof 11 24 47

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. James CemeteryLocation Harre de Grace, md.18. Funeral director Elmer E. BullardAddress 556 Lewis St. H-de-G. md.19. Nov. 21 19 47 G. L. Lewis m.d.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19-47 19. 9 20 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-17-47 19. 11-19-47 19.

and that I last saw him alive on 11-19-47 19.

Immediate cause of death Cirrhosis of the liver
 DURATION 7

Due to

Due to

Due to

Due to

Other conditions Internal hemorrhageHydrocele (left)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

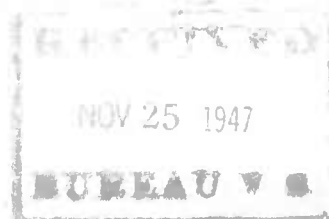
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Vogues m.d.Address Hospital - H. de Grace Date signed 11/20/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Harford
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Eugene Brown

3. (b) Social Security Number

4. Sex male 5. Color or race col 6.(a) Single, married, widowed, or divorced widower
 6.(b) Name of husband or wife Ellie Curry
 B.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 13 1887
 8. AGE: Years 60 Months 7 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Bel Air Harford co, md
 (Town, county, and state)
 10. Usual occupation Day Laborer
 11. Industry or business

FATHER 12. Name Tom Brown
 13. Birthplace Balto Co, md
 MOTHER 14. Maiden name Amanda Hall
 15. Birthplace Harford Co md

16. Informant Mrs Herbert Bond
 Address Janettville md.
 17. Buried Date thereof Nov 27-77
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Tabernacle
 Location Benson Harford co, md
 18. Funeral director Martin Skurtz
 Address Terrettville md

19. 11/25 49 P. Howard
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 47 1947 at 3:30 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____
 Immediate cause of death Accidental Drowning

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide A accident Date of 11/24/47
 Where did injury occur? Bel Air Harford md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) small stream
 Means of Injury Fell in stream Injured at work? no

23. SIGNATURE Gerald C Palmer M.D.
Acting Deputy Medical Examiner
 Address Bel Air, md Date signed 11/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REGISTERED

REGISTERED

RECEIVED

NOV 28 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1009785-

1. PLACE OF DEATH:

County HARFORDCity or town HAVER DE GRACE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

HARFORD MEMORIAL HospitalHow long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HARFORDCity or town HAVER DE GRACE
(If outside city or town limits, write RURAL and give nearest town)Street No. RD # 2

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mr. Alexander Bungori

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Spandora Bungori6. (c) If alive, give age 63 years

7. Birth date of

deceased (mo., day, yr.) October 5, 1890

8. AGE:

Years

Months

Days

If less than one day

57112

hrs.

min.

9. Birthplace

(Town, county, and state)

Italy

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Joseph Bungori

13. Birthplace

Italy

MOTHER

14. Maiden name

Theresa ?

15. Birthplace

Italy

16. Informant

Address

Mr. Spandora Bungori

Address

near Haver de Grace RD #2

17. Burial

(Burial, cremation, or removal. Which?)

Burial

Date thereof

11/13/47

(month) (day) (year)

Cemetery or crematory

Location

St. Ann

Address

Haver de Grace

18. Funeral director

Address

Funerary & Rem

Address

Haver de Grace

19. (Date rec'd by registrar)

19. 47

Nov. 14G. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 19 47 at 3 28 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 - 47 19 47 to Nov. 12/1947and that I last saw him alive on Nov. 11 19 47

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Bilateral ligation of
superficial femoral veinsDate of op. 11-10-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John F. Niguen

M. D. or other

Address Haver de Grace Md Date signed 11/15

RECEIVED

NOV 18 1947

COMMUNICATIONS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH \times
 2411 N. Charles St., Baltimore 48a
CERTIFICATE OF DEATH

10098
 182
 Reg. Dist. No.

1. PLACE OF DEATH:

County Hartford
 City or town Bel Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md County Hartford
 City or town Bel Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAMELaura A Cain**3. (b) Social Security Number**

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept 4 - 1864
 8. AGE: Years 83 Months 2 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Hartford Co. Md
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name James M Cain

13. Birthplace Md

MOTHER 14. Maiden name Elizabeth Keen

15. Birthplace Md

16. Informant Miss FANNIE Cain

Address Bel Air, Md

17. Burial Date thereof Nov 7/47
 (Burial, cremation, or removal. Which?) (month) day (year)

Cemetary or crematory St Ignatius

Location Hic Key, Hartford Co., Md

18. Funeral director J. J. Smith

Address Bel Air Md

19. 11/6 1947 Roseella Lowndes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1947 at 3³⁰ P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1926 to Nov 5 - 1947
 and that I last saw her alive on Nov 5 - 1947

Immediate cause of death Carcinoma of uterus, primary in cervix

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Roseella Lowndes M. D. or other

Address Bel Air Md Date signed 11/6/47

RECEIVED

NOV 10 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1009780

1. PLACE OF DEATH:

County HARFORDCity or town NEAR EDGEWOOD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Van Bibber, Edgemund R.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

SAMUEL MCHEEK

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Core U. Cheek6. (c) If alive, give age 51 years

7. Birth date of

deceased (mo., day, yr.)

Jan. 2, 1891

8. AGE:

Years

Months

Days

If less than one day

56106

hrs.

min.

9. Birthplace

Ennis, Alleghany Co. N.C.
(Town, county, and state)

10. Usual occupation

Government Employee

11. Industry or business

Army Chemical Center

12. Name

Nenderson Cheek

13. Birthplace

North Carolina

14. Maiden name

Millie Niggans

15. Birthplace

North Carolina

16. Informant

Core U. Cheek

Address

Edgemund R.D. Md

17. Date thereof

(Burial, cremation, or removal. Which?)

Nov. 10, 1947
(month) (day) (year)

Cemetery or crematory

Reins - Stundinut

Location

Independence, Va.

18. Funeral director

Howard R. McCombs

Address

Abingdon Maryland

19. Date rec'd by registrar

Nov 10 1947
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 19 47 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....
and that I last saw him.....alive on.....19.....

Immediate cause of death

CEREBRAL CONVULSION
SHOCK

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

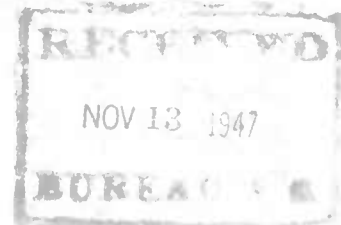
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of 11/8/47Where did injury occur? NEAR EDGEWOOD HARFORD MD
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public RoadMeans of injury STRUCK BY AUTO Injured at work? No

23. SIGNATURE

Address Abingdon, Md Date signed 11/8/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10100
 Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Street Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 53 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Street Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Joseph M. Davis

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Elihu Davis
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 2 - 1867
 8. AGE: Years 80 Months 8 Days 0 It less than one day _____ hrs. _____ min.

9. Birthplace Harford Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John G. Gabeath
 13. Birthplace Harford Co. Md.

14. Maiden name Isabella Wiley
 15. Birthplace York Co. Md.

16. Informant William Davis
 Address Street, Md.

17. Burial Date thereof Nov 5, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Waverly cemetery
 Location Delta, Pa.

18. Funeral director Hubert P. Parker
 Address Delta, Pa.

19. Nov. 4, 1947 M. D. Kirk
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2nd 47 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Nov 2nd 47 and that I last saw him alive on Nov 1st 47

Immediate cause of death Carcinoma of abdomen with neck metastasis. DURATION June, 1947

Due to _____

Due to _____

Other conditions Fractured hips Sept 1947

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Acc. Date of 9/18/47
 Where did injury occur? Rome - Harford Co.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Fell on floor Injured at work? _____

23. SIGNATURE Joseph A. Bunt, M.D. M. D. or other _____

Address Delta, Pa. Date signed 11/4/47

RECEIVED
NOV 18 1947
BUREAU V. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County HarfordCity or town Rocks
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Rocks
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) if veteran, name War _____

3. (a) FULL NAME

Godfrey Diethelm

3. (b) Social Security Number

4. Sex

M.

5. Color or race

w

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 2, 1872

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

75526

hrs.

min.

9. Birthplace

Switzerland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Godfrey Diethelm

13. Birthplace

Sulzgen, Switzerland

14. Maiden name

Bairborn Bernecht

15. Birthplace

Rapperswil, St Gallen, S.

16. Informant

Clara Rosie Diethelm

Address

Rocks, Md

17.

(Burial, cremation, or removal) Which?

Date thereof

Dec. 2, 1947
(month) (day) (year)

Cemetery or crematory

St Ignatius

Location

Hickory, Md

18. Funeral director

Martin E. Furtz

Address

Garrettsville, Md

19.

Dec. 2
(Date rec'd by registrar)

20.

1947 Thomas R. Brown

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 28,

19

47, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 29

19

47, toNov 28

19

and that I last saw him alive on

Nov 27

19

Immediate cause of death

Cerebral Hemorrhage

DURATION

5 days

Due to

Due to

Other conditions

Ch. myocardial DiseaseGen. Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

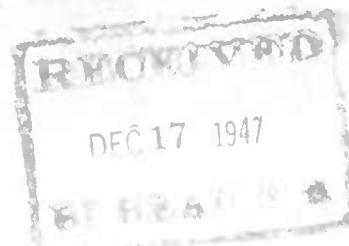
23. SIGNATURE

Willard P. Hedson

M. D. or other

Address

Forest Hill MdDate signed 11/29/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10510 185-

1. PLACE OF DEATH:

County HARFORD
 City or town HAVERDE GRACE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 HRS.
 Hospital, institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL
 How long in hospital or institution? 3 HRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HARFORD
 City or town CHARLINGTON
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) MO
 2.(a) If veteran, name war _____

3.(a) FULL NAME

GWYN RAY ELLER

3.(b) Social Security Number

MO

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife None
None 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) DECEMBER 27, 1943

8. AGE: Years 3 Months 10 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace HARFORD CO., MARYLAND
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name RAY ELLER

13. Birthplace WILKESBORO NORTH CAROLINA

14. Maiden name CARRIE BELL NICHOLS

15. Birthplace JOHNSON CO., TENNESSEE

16. Informant Ray Ellier

Address Charlinton, Md.

17. Removal Date thereof Nov. 12, 1947
 (burial, cremation, or removal of body) (month) (day) (year)

Cemetery or crematory Arbor Grove Cem

Location Wilkes Co., N. C.

18. Funeral director H. S. Bailey

Address Charlinton, Md.

19. Nov. 11 19 47 G. L. Lewis m.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 11, 1947 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/10/47 19 11/11/47 19

and that I last saw him alive on 11/11/47 19

Immediate cause of death Bronchopneumonia

Due to Acute laryngo-tracheo-bronchitis

Due to _____

Other conditions _____

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John F. Wigney Md M. D. or other

Address Haverde Grace Date signed 11-11-47

RECORDS

NOV 13 1947

BUREAU

Reg. Diat. No. 780

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?.....			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... City or town..... (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....		
3.(a) FULL NAME MARY A. GABER			3.(b) Social Security Number		
4. Sex Female			5. Color or race White		
6.(a) Single, married, widowed, or divorced Widowed			6.(c) If alive, give age..... years		
7. Birth date of deceased (mo., day, yr.) June 8, 1883			8. AGE: Years Months Days If less than one day 64 5 9 hrs. min.		
9. Birthplace Maryland (Town, county, and state)			10. Usual occupation None		
11. Industry or business			12. Name Daniel Russell		
13. Birthplace Unknown			14. Maiden name Unknown		
15. Birthplace			16. Informant Evelyn S. Watts Address 2736 W. Howard St., Baltimore		
17. (Burial, cremation, or removal. Which?) Burial Date thereof Nov 20, 1947 (month) (day) (year) Cemetery or crematory Jerusalem Christian Location Joppa R.D. Howard E. McCombs			18. Funeral director Aberdeen Md Date rec'd by registrar Nov 20 47		
19. (Date rec'd by registrar)			20. DATE OF DEATH Nov. 17 1947 at 5:30 P.M.		
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19..... and that I last saw him alive on 19..... Immediate cause of death Fracture of skull Intracranial Hemorrhage Fracture of R. and L. femur Lower legs Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Accident Where did injury occur? near Joppa Harbor Md (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Boat # 152 Means of injury Struck by auto Injured at work? No 23. SIGNATURE J. Ramsey M.D. Address Aberdeen Md Date signed Nov 17 1947					

RECEIVED

NOV 24 1947

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity Scarboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Scarboro
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

NANCY LEE HARDIMAN

3. (b) Social Security Number

No4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) Aug. 12, 1947 6. (c) If alive, give age _____ years8. AGE: Years 3 Months 12 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Elkton, Cecil Co., Md.
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name James W. Hardiman13. Birthplace White Sulphur Springs, W. Va.14. Maiden name Alice S. Korakos15. Birthplace Crownsville, Md.16. Informant Alice S. HardimanAddress Street, Md. Rural17. Burial Nov. 29, 1947 Date thereof (month) (day) (year)Cemetery or crematory Ascension Cem.Location Harford Co., Md.18. Funeral director H. S. BaileyAddress Charlottesville, Md.19. Nov. 28 19 47 M. G. Hork Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1947 19 _____ at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Pneumonia - Type not known

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. W. Ramsey

Sp. Med. Examiner or other

Address Abertown, Md. Date signed 11/27/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 3 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10509

131a

18418

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19.47 at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 2 -

19.47 to Nov 21

19.47

and that I last saw her alive on

Nov 19

19.47

Immediate cause of death

DURATION

Ch. Myocardial Disease

Due to

Due to

Other conditions

Ch. Cardiac-Vascular
Renal disease with hypertension
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

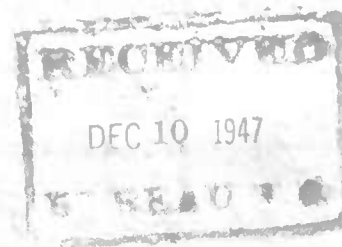
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10103 185

1. PLACE OF DEATH:

County HarfordCity or town Harre De Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. Cordova Apts - Lake Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

SADIE KATZ JACOBS

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Morris

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 49 Months Days If less than one day
hrs. min.9. Birthplace New York City
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Mendel Katz13. Birthplace Russian

MOTHER

14. Maiden name Mary Katz15. Birthplace Russian16. Informant Morris JacobsAddress Cordova Apts Lake Drive17. (Burial, cremation, or removal, Which?) BurialDate thereof 11-6-47
(month) (day) (year)Cemetery or crematory Beth Shalom HebrewLocation Blair Road18. Funeral director Jack Lewis IncAddress 2100 Canton Place19. 11-6-47

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1947 at 11:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death

FRACTURE OF SKULL
INTRACRANIAL HEMORRHAGE

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of Nov. 3, 1947Where did injury occur? ABERDEEN HARBOR Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) ROUTE # 40Means of injury AUTO ACCIDENT Injured at work? No23. SIGNATURE J. H. Ramsey M.D.Address Aberdeen, Md Date signed 11/8/47

State

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Harford
 City or town... Magnolia
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 year
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Harford
 City or town... Magnolia
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Rebecca

3. (b) Social Security Number

Jeffers

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 8. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Nov. 19, 1872

8. AGE: Years 75 Months 0 Days 1 If less than one day hrs. min.

9. Birthplace... Magnolia, Harford, Md
 (Town, county and state)
none

10. Usual occupation... none

11. Industry or business

12. Name... Benjamin Jeffers

13. Birthplace... Poole's Island, Md

14. Maiden name... Rebecca E. Sitzinger

15. Birthplace... Harford Co., Md

16. Informant... Mrs. Blanche Stillman

Address... Magnolia Md

17. Burial... Burial Date thereof... Nov. 23, 1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Cokesbury, Abingdon

Location... Abingdon, Harford, Md

18. Funeral director... Howard R. McCombs

Address... Abingdon Md

19. Nov. 22 1947 Mary M. Mouldale

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1947 at 8:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Nov 20 1947

and that I last saw her alive on November 20 1947

Immediate cause of death.....

Atherosclerotic cardiovascular disease

Due to.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Levold C Palmer MD

M. D. or other

Address Beth A in Md. Date signed 11/20/47

RECEIVED
NOV 26 1947
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10105

Reg. Dist. No. 185

1. PLACE OF DEATH

County HarfordCity or town Harford Beach
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Maryland County HarfordCity or town Harford Beach
(If outside city or town limits, write RURAL and give nearest town)Street No. 520 Young
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Henry Jones

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

(dec.)

7. Birth date of deceased (mo., day, yr.)

? 1888

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

49

9. Birthplace

Maryland

(town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

12. Name

Bessie Jones

13. Birthplace

Maryland

14. Maiden name

Bessie Jones

15. Birthplace

Maryland

16. Informant

James PittAddress 520 Young St.

17. Burial

BurialDate thereof 4/6/47

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Swan Creek

Location

near Harford

18. Funeral director

Pennington & Son

Address

Harford Beach, Md.

19. Nov. 6

19 47G. L. Lewis

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 19 47 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 3 19 47 to Nov 3 19 47and that I last saw him alive on Nov 3 19 47

Immediate cause of death

Arteriosclerotic Heart Disease
Internal Hemorrhage

DURATION

Due to

Stroke

Due to

Hemorrhage

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles J. Tolson

M. D. or other

Address Harford Beach, Md. Date signed Nov 4 1947

RECEIVED
NOV 7 1947
BUREAU 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10106/85 - 98d

1. PLACE OF DEATH:

County Harford
 City or town Havee de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 days
 Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 611 W. Bel Air Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr Thomas B. Kimmamon

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ells May Bishop

7. Birth date of deceased (mo., day, yr.)

Sept. 17, 1874

6. (c) If alive, give age

80 years

8. AGE:

Years

Months

Days

If less than one day

731hrs.min.

9. Birthplace

Talbot Co. Md.
(Town, county, and state)

10. Usual occupation

Retired Taxman

11. Industry or business

Taxman

FATHER

12. Name

Laurel Kimmamon

13. Birthplace

Talbot Co. Md.

MOTHER

14. Maiden name

Laurel J. Callahan

15. Birthplace

Maryland

16. Informant

Mrs. Thomas B. Kimmamon

Address

611 W. Bel Air Ave. Aberdeen

17. Burial

Burial

Date thereof

Nov 5 1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Landon Park

Location

Baltimore Md

18. Funeral director

Henry Taxman & Son

Address

Aberdeen, Md.

19. (Date rec'd by registrar)

Nov. 4 19 47G. L. Lennix M. D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3rd 19 47 at 9 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 26 - 47 19 to Nov 3rd 19 47and that I last saw him alive on Nov. 2 - 47 19

Immediate cause of death

Myocardial infarction

DURATION

8 days

Due to

Coronary arteriosclerosis 2 years

Due to

Coronary arteriosclerosis 2 years

Other conditions

Hypertensive heart disease

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

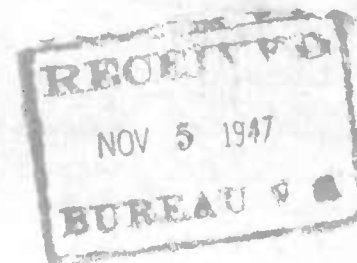
23. SIGNATURE

John F. Voznera MD

M. D. or other

Address

Hospital Hume de Grace Date signed 11/5/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)Street No. 846 Locust
(If rural, give LOCATION)

2.(a) If veteran, name War.....

3. (a) FULL NAME

Baby Boy Macon

3. (b) Social Security Number

4. Sex

M.

5. Color or race

C.

6.(a) Single, married, widowed, or divorced

newborn infant

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 9 - 47 @ 10³⁰ PM.

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

3 hrs.10 min.

9. Birthplace

Harford
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

11/11/47
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 19 47 at 2⁴⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 9 - 19 47 to Nov. 10 19 47and that I last saw him alive on Nov. 9 - 47 19

Immediate cause of death

Pulmonary atelectasis

DURATION

3 h³

Due to

aspiration of mucus

Due to

Other conditions

prematurity (8 mos.)intermittent life.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John F. Vogner M. D. or otherAddress Harford Mem. Hospital Date signed Nov. 10 - 47

RECEIVED

NOV 13 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

10108

1316

1. PLACE OF DEATH:

County HarfordCity or town Harford Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Harford Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 117 Dearer St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Byrd Miller

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 13, 1928

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

19612-

hrs.

min.

9. Birthplace

Long Branch, N.J.
(Town, county, and state)

10. Usual occupation

School

11. Industry or business

A.P.S. Md.

FATHER

12. Name

David Russell Miller

13. Birthplace

N.J.

MOTHER

14. Maiden name

Alice R. Dyke

15. Birthplace

N.J.

16. Informant

Mr. David Russell Miller

Address

117 Dearer St. Harford Grace, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 28, 1947
(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Harford Grace, Md.

18. Funeral director

R. Madison Mitchell

Address

Harford Grace, Md.

19.

Nov. 261947G.L. Lewis M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1947 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 25 to 25 19 47and that I last saw him alive on Nov. 24 19 47Immediate cause of death Coronary HeartFailure

DURATION

Due to Phenemate Heart DiseaseDue to Chronic glomerulonephritisOther conditions HypertensionBrachial asthma.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Daniel D. Dole, M.D.Address Harford Grace, Md.Date signed 26 Nov. 1947

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 28 1947
U.S. AIR FORCE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10109

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Hanford
 City or town Shedden Md. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 76 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Hanford
 City or town Shedden Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Street Lane
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mamie E. Mitchell

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife B. Silver Mitchell
 7. Birth date of deceased (mo., day, yr.) January 17th 1871
 6. (c) If alive, give age 77 years
 8. AGE: Years 76 Months 10 Days If less than one day hrs. min.

9. Birthplace Shedden Island Hanford Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George A. Courtney
 13. Birthplace Hanford Co. Md.
 14. Maiden name J. Greble
 15. Birthplace Phila. Pa.

16. Informant Mr. B. Silver Mitchell
 Address Shedden Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 20, 1947
 (month) (day) (year)
 Cemetery or crematory Grove

Location Shedden Md.
 18. Funeral director Henry Tarrington & Sons

Address Shedden Md.
 19. Nov. 19 19 47 Nellie H. Riley
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 19 47 at 5:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 19 47 to Nov. 18 19 47
 and that I last saw him alive on Nov. 17 19 47

Immediate cause of death Carcinoma of the liver
(primary)

Due to
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Thos. P. Thompson
 M. D. or other
 Address Shedden Md. Date signed Nov. 18/47

RECEIVED

NOV 25 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10110

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity or town Bel Air, R.D. #2
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 daysHospital, institution, or street address where death occurred:
Mountain Green HospitalHow long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Gilbert Poca

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

✓

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 17 19 47 at 2:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 5 19 42 to Nov 12 19 47and that I last saw her alive on Nov 16 19 47

Immediate cause of death

Chr. Myocardial Disease

DURATION

10 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Leonard P. Hudson

M. D. or other

Address Forest Hill, Md Date signed 11/17/47

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Sept 26 1889

8. AGE:

Years

Months

Days

If less than one day

88122

hrs.

min.

9. Birthplace

Harford Co. Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

John W. Poca

13. Birthplace

Harford Co. Maryland

14. Maiden name

Cassandra Gilbert

15. Birthplace

Harford Co. Maryland

16. Informant

Mrs. Paul Wilson

Address

Bel Air, Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

Nov 19/47
(month) (day) (year)

Cemetery or crematory

MT Zion

Location

Mountain Green

18. Funeral director

Joseph J. Foster

Address

Bel Air, Md

19.

11/18
(Date rec'd by registrar)

19

47
Paula Howard

Registrar

RECEIVED

NOV 21 1947

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10111

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
 City or town near Aberdeen Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 83 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Aberdeen Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Annie May Paston

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband

Samuel S. Paston

7. Birth date of deceased (mo., day, yr.)

March 3rd 1864

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

83713

hrs.

min.

9. Birthplace

Aberdeen Harford Co., Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Louis Todd

13. Birthplace

Aberdeen, Md.

14. Maiden name

Virginia Osborne

15. Birthplace

Aberdeen, Md.

16. Informant

Miss Alice E. Paston

Address

Aberdeen Md. R.F.D.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Nov. 18, 1947
(month) (day) (year)

Cemetery or crematory

Grove

Location

Aberdeen Md.

18. Funeral director

Henry Tarrington Sons

Address

Aberdeen, Md.

19.

(Date rec'd by registrar)

19

47Nellie H. Riley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 16

19

47 at 7:05 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10

19

47 toNov. 16

19

and that I last saw him alive on

Nov. 16

19

47

Immediate cause of death

Coronary thrombosis

DURATION

6 hrs.

Due to

arteriosclerosis

Due to

hypertension

Other conditions

mitral insufficiency

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. P. Thompson M.D.

M. D. or other

Address

Aberdeen Md.Date signed Nov 18/47

NOV 25 1947

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

10112

1. PLACE OF DEATH:

County Harford
 City or town Have de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred
Harford Memorial Hospital
 How long in hospital or institution? 1 day 10 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Cecil
 City or town Ferryville Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Frenchtown Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Baby Boy Pittman

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced
newborn infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1947. 6. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days 1 It less than one day 10 hrs. _____ min.

9. Birthplace Have de Grace, Harford Co., Md.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Lidney A. Pittman
 13. Birthplace Eldorado, Arkansas

14. Maiden name Beta De Mar
 15. Birthplace Ant. de Mar, Cecil Co., Md.

16. Informant Mrs. C. F. De Mar
 Address Ferryville, Md.

17. Burial Date thereof Nov. 28, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt. Erin
Have de Grace, Md. Rural

18. Funeral director W. A. Patterson & Son
 Address Ferryville, Md.

19. Nov. 28 19 47 G. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 25, 1947 to Nov. 26, 1947 and that I last saw him alive on Nov. 26, 1947

Immediate cause of death Central respiratory failure and anoxia

Due to Prematurity

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

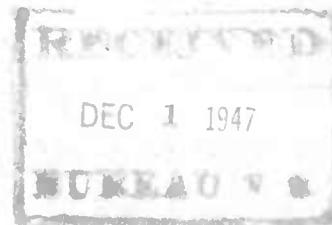
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE John F. Noguera MD
 Address Hospital - Have de Grace M. D. or other
 Date signed 11-26-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

10113

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital
 How long in hospital or institution? 6 hours

3. (a) FULL NAME

Linda Rudd - (baby girl)

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

newborn infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

November 24, 1947
 8. AGE: Years Months Days If less than one day
8 hrs. — min.

9. Birthplace

street, Harford, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Nov. 24

19. 47

A. L. Lewis M.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford
 City or town Street
 (If outside city or town limits, write RURAL and give nearest town)

Street No. —
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1947 at 8 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24, 1947 to same 19 —

and that I last saw him alive on same 19 —

Immediate cause of death Respiratory failure

Due to Prematurity (6 1/2 to 7 months of intrauterine life)

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

An autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

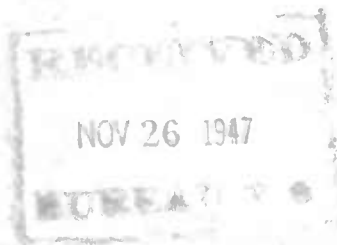
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE John F. Noguera M.D.

Address Hospital - Harre de Grace Date signed 11/24/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Prince George's
 City or town White Hall
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince George's
 City or town White Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2527 B.D.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Agness Rutledge
 6.(c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) July 8, 1881
 8. AGE: Years 66 Months 4 Days 7 If less than one day
 hrs. min.

9. Birthplace Hyattsville Md
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Farming
 12. Name John P. Rutledge
 13. Birthplace Hyattsville Md
 14. Maiden name Elyth Nelson
 15. Birthplace Hyattsville Md
 16. Informant Nelson P. Rutledge
 Address White Hall Md
 17. Burial Date thereof Nov 18, 1947
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Bethel
 Location White Hall Md
 18. Funeral director W. H. Brown
 Address 5 Ann Grove Rd
 19. Nov 18, 1947 Registrar Thomas R. Brown
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15, 1947 at 9 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APR 13, 1947 to Nov 15, 1947
 and that I last saw him alive on Nov 15, 1947
 Immediate cause of death Carcinoma of Bladder
 DURATION 1 year
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations Carcinoma of Bladder
 Date of op. 1947

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Robert Barthel MD
 Address Forest Hill Md M. D. or other
 Date signed 11/17/47

RECEIVED

NOV 20 1947

BURFA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10115

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
City or town Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Fountain Green Hospital
2 weeks

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Joppa
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Theodore Lacy Silling

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bessie B. Silling

7. Birth date of deceased (mo., day, yr.) June 14, 1878 6. (c) If alive, give age _____ years

8. AGE: Years 69 Months 5 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Augusta Co. Va.
(Town, county, and state)

10. Usual occupation Retired Foot Employee

11. Industry or business Army General Center

12. Name George F. Silling

13. Birthplace VA

14. Maiden name Emma Wiseman

15. Birthplace VA

16. Informant Mrs Bessie B. Silling

Address Joppa Maryland

17. (Burial, cremation, or removal, Which?) Burial Date thereof Nov 23, 1947
(month) (day) (year)

Cemetery or crematory Bel Air Burial Park

Location Bel Air Harford Co Maryland

18. Funeral director Howard K. McComarson

Address Abingdon Harford Co Maryland

19. 11/27 19 47 Priscilla Lowood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 19 47 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 - 19 47 to November 23 19 47 and that I last saw him alive on November 23 19 47

Immediate cause of death Coronary Thrombosis

DURATION

20 hrs.

Due to _____

Due to _____

Other conditions Congestive heart failure - 1 yr. ago
Coronary Thrombosis 1 yr. ago.
(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Willard P. Hedson

Address Forest Hill Md Date signed 11/24/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 29 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10116

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
 City or town Harford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Md. County Harford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

George F. Singleton

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 4-11-47

8. AGE: Years — Months 6 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Harford, Md.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Andrew Zellman
 13. Birthplace Md.

14. Maiden name Bernadine Singleton
 15. Birthplace Md.

16. Informant Mrs. George P. Singleton
 Address Aberdeen, Md.

17. Burial Date thereof Nov. 4, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Churchville Episcopal Ch. & P.
 Location Harford Co., Md.

18. Funeral director R. Madison Mitchell
 Address Harford Co., Md.

19. Nov. 4 19 47 G. L. Lewis M. D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1947 at 4:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2, 1947 to same 19 47
 and that I last saw him alive on same 19 47

Immediate cause of death Acidosis
Enteritis
dehydration

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE John F. Vignone M.D.
 Address Harford Co., Md. Date signed Nov. 4, 1947

RECEIVED

NOV 5 1947

BUREAU P.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

88a

10117

Reg. Diat. No.

182

1. PLACE OF DEATH:

County..... HarfordCity or town..... Bel-air
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md County..... HarfordCity or town..... Bel air
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Stretta Harkins Smith

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widow6.(b) Name of husband or wife..... John Hamilton Smith

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

June 14, 1878

8. AGE:

Years

Months

Days

If less than one day

6953

hrs.

min.

9. Birthplace..... Chestnut Hill Harford Co. Md.
(Town, county, and state)

10. Usual occupation.....

House wife

11. Industry or business

FATHER
MOTHER

12. Name.....

John W. Harkins

13. Birthplace.....

Chestnut Hill, Md.

14. Maiden name.....

Elizabeth Ann Pyle

15. Birthplace.....

Baltimore, Md.16. Informant..... Mr. John S. Smith

Address

Bel-air, Md.17. Burial Date thereof..... Nov 20, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Deer CreekLocation..... Chestnut Hill Harford Co. Md.18. Funeral director..... Martin G. Kutz

Address

Garrettsville, Md.19. 11/19/47 P. Fowood
(Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 17 19 47 at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 15 19 47 to Nov 17 19 47and that I last saw her alive on Nov 16 19 47

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

5 1/2 days

Due to.....

Due to.....

Other conditions.....

Essential Hypertension10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....

Willard R. Hudson

M. D. or other

Address..... Forest Hill, Md. Date signed..... 11/17/47

REC-100
NOV 21 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 184182

1. PLACE OF DEATH:

County Harford
 City or town Harlington Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Harford
 City or town Harlington Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION) no
 2(a) If veteran, name War

3. (a) FULL NAME

James R. Smith

3. (b) Social Security Number

215-246132

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

8. (b) Name of husband or wife Elizabeth

Alive

7. Birth date of deceased (mo., day, yr.) Aug 18 1863

8. AGE: Years Months Days If less than one day

74 2 24 hrs. min.

9. Birthplace Pulaski Co., Va.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business On farm

12. Name Wm. Smith

13. Birthplace Pulaski Co., Va.

14. Maiden name Nancy Odile

15. Birthplace Pulaski Co., Va.

16. Informant Mrs. Elizabeth Smith

Address Harlington Md. Rural

Buried

Date thereof Nov. 23 1947

(Burial, cremation, or removal, where)

Cemetery or crematory Oak Grove Cem

Location Harford Co. Md.

18. Funeral director H. J. Bailey

Address Harlington, Md.

Nov. 23 19 47 M. V. Turk

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10/21 19 47 at 3 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 1947 to Nov 19 47

and that I last saw him alive on Oct. 15 19 47

Immediate cause of death Old Age

Due to Generalized Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dudley Phelps MD

Address Harlington, Md.

Date signed 11/21/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 10 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10118 182

1. PLACE OF DEATH:

County HarfordCity or town Rural Bel Air
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6.22

Hospital, institution, or street address where death occurred:

Harford Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Rural Harford Grace P.D. #2
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James Wallace Standiford

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife ella C. Standiford7. Birth date of deceased (mo., day, yr.) Aug. 21, 1963

6. (c) If alive, give age _____ years

8. AGE: Years 84 Months 2 Days 20 If less than one day _____ hrs. _____ min.9. Birthplace Md.
(Town, county, and state)10. Usual occupation Retired Store Keeper

11. Industry or business _____

12. Name Garret Standiford13. Birthplace Md.14. Maiden name Heater (unk)15. Birthplace Md.16. Informant Mr. Chester A. De BaughAddress Harford Grace, Md. P.D. #217. Burial Date thereof Nov. 16, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rock RunLocation Harford Co. Md.18. Funeral director R. Madison MitchellAddress Harford Grace, Md.19. 11/14 47 Priscilla Toward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1947 at 11:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 - 1947 to Nov 13 1947and that I last saw him alive on Nov 13 1947Immediate cause of death Chr. Myocardial Disease

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Willard P. Hudson

M. D. or other

Address Forest Hill, Md. Date signed 11/14/47

RECEIVED

NOV 18 1947

BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10119
 Reg. Diat. No. 181

1. PLACE OF DEATH:

County Harford
 City or town Aberdeen Md Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Aberdeen Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Level
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William L Tibbs

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Ocie L Tibbs
 7. Birth date of deceased (mo., day, yr.) April 8th 1875
 6.(c) If alive, give age 61 years
 8. AGE: Years 72 Months 8 Days 12 If less than one day hrs. min.

9. Birthplace Lafayette Co. W. Va
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Robert L Tibbs

13. Birthplace Virginia

14. Maiden name Jane Powers

15. Birthplace Virginia

16. Informant Mrs. William L Tibbs

Address Aberdeen Md. R.D. #2

17. Rural Date thereof Nov. 19, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Zion

Location Bel Air Rural

18. Funeral director Henry Tarrington Sons

Address Aberdeen Md

19. Nov. 18 19 47 Nellie H. Tiber
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 19 47 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 37 to Nov 19 47
 and that I last saw him alive on Nov 16 19 47

Immediate cause of death Coronary thrombosis DURATION 10 hrs

Due to arteriosclerosis C. V. Disease 2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Ralph Kelly M.D. M. D. or other

Address Chesapeake Bay Date signed Nov 17

RECEIVED

NOV 25 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10120

Reg. Diat. No. 182

1. PLACE OF DEATH:

County Harford
City or town Streett, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
City or town Streett, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Chester Tome

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1947

8. AGE: Years 6 Months 4 If less than one day
.....hrs.min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Christopher Tome
13. Birthplace York Co. Pa.

MOTHER 14. Maiden name Gladys Grove
15. Birthplace Delta, Pa.

16. Informant Christopher Tome
Address Streett, Md.

17. Burial Date thereof Nov. 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Shenberger Chapel cem.
Location Koonrods, Pa.

18. Funeral director Hubert P. Harkins
Address Delta, Pa.

19. 11/9 47 Priscilla Toward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1947 19 at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Peripheral Vascular Collapse
Due to Bronchopneumonia

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

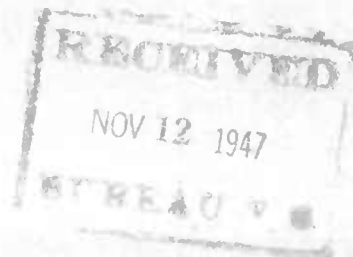
23. SIGNATURE Dr. James W. D.
Address Aberdeen, Md. Date signed 11/9/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Peripheral Vascular Collapse



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10121

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No. -
(If rural, give LOCATION)
2.(a) If veteran, name war -

3. (a) FULL NAME

Annie Cecelia Townsley

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife James Oliver Townsley
6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) July 24 1866

8. AGE: Years 81 Months 3 Days 12 If less than one day - hrs. - min.

9. Birthplace Baltimore Co md
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business -

12. Name Mrs. P. C. C.

13. Birthplace md.

14. Maiden name Hannah Walker

15. Birthplace Harford Co md.

16. Informant Mrs. Margaret Townsley

Address Owings Mills md.

17. Burial Date thereof Nov 9-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Janettsville

Location Janettsville md

18. Funeral director Martin Skurtz

Address Janettsville

19. 9/17 47 Priscilla Toward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1947, at 11:42 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20 1947 to Nov 5 1947
and that I last saw her alive on Nov 5 - 1947

Immediate cause of death Coronary Thrombosis DURATION 20 hrs.

Due to -

Due to -

Other conditions Essential Hypertension 3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P. Anderson M. D. or other

Address Forest Hill Md Date signed 11/6/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 11 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County HarfordCity or town Magnolia
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1 mo.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Magnolia
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Alice Van Fossen

3. (b) Social Security Number

218-09-4791

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow6. (b) Name of husband or wife Charles T. Van Fossen

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Sept. 9, 1862

8. AGE:

Years

Months

Days

If less than one day

85213

hrs.

min.

9. Birthplace Charles T. Van Fossen Baltimore, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name

McKeldin

13. Birthplace

MOTHER

14. Maiden name

Sophie

15. Birthplace

16. Informant

Mr. John R. Van Fossen

Address

Magnolia, Md.

17.

Burial

Date thereof

11/25/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Olivet Cem.

Location

Baltimore, Md.

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19.

(Date rec'd by registrar)

11/2447A. C. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 19 47 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2019 47to Nov 2219 47and that I last saw him alive on Nov 22 19 47

Immediate cause of death

Cerebral hemorrhage

DURATION

3 daysDue to generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jed O. Hodous, M.D.

M. D. or other

Address

Edgewood Md

Date signed

11-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10122

181

1. PLACE OF DEATH:

County HARFORD
 City or town ABERDEEN
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 YRS
 Hospital, institution, or street address where death occurred:
PHILADELPHIA ROAD
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Chesden
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 129 N. Philadelphia
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

JAMES

A

WALKER

3. (b) Social Security Number

232-24-0502

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

7. Birth date of ☒ deceased (mo., day, yr.) July 10 - 1892
 6. (c) If alive, give age — years

8. AGE:

Years

Months

Days

It less than one day

55

3

25

hrs.

min.

9. Birthplace

Brownfield Fayette Co. Pa.
 (Town, county, and state)

10. Usual occupation

Restaurant Employee

11. Industry or business

FATHER

12. Name

James B. Walker

13. Birthplace

Penna.

MOTHER

14. Maiden name

Clara Walker

15. Birthplace

Fairmont W. Va.

16. Informant

Clara Reynolds

Address

326 Salisbury St. Meyersdale Pa.

17.

Burial
 (Burial, cremation, or removal. Which?)

Date thereof

Nov. 5, 1947
 (month) (day) (year)

Cemetery or crematory

Union Cemetery

Location

Meyersdale Pa.

18. Funeral director

William C. Price

Address

Meyersdale, Penna.

19.

Nov. 5, 1947
 (Date rec'd by registrar)

19

Nellie H. Lister
 Registrar

23. SIGNATURE

J. Ramsey M. D.
 Address Aberdeen, Md. Date signed 11/6/47

MEDICAL CERTIFICATION

Approx

20. DATE OF DEATH Nov. 5 1947 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. — alive on — 19— at — 19—

Immediate cause of death

MASSIVE GASTRIC HEMORRHAGE

DURATION

Due to

PROBABLE ULCER OR ESOPHAGEAL

Due to

VARICES

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of —

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

NOV 29 1947

RECEIVED

NOV 18 1947

BUREAU